My Life, My Health:
Living with Chronic Conditions

Welcome to the Pre-Workshop Participant Survey

Thank you for taking a few minutes to answer some brief questions. While you may leave any question blank, we encourage you to complete the survey. Summarized information from all participants will help us demonstrate how this program is serving people who will benefit the most. Your responses are extremely helpful.

This survey is the first in a three part series, there will be a Post -Workshop survey at the end of program, and a final survey 6 months after your completion of My Life, My Health. This survey asks for basic information about you. At the bottom of this page please fill in your name and contact information; this is only for the purpose of matching your information with your attendance and reaching you for the follow-up survey. Once matched, your name will be removed from all survey responses. Your name will not be recorded in any database.

Your form will be kept confidential. Your responses will not affect any services or programs you are getting. If you have any questions about what is being asked, please ask your Group Leader.

Thank you again for taking time to complete this important survey!

Name: _____ _____

Address:_____ _____

City, State, Zip:_____ _____

Telephone: Day ( )_____-_____ **Evening ( )**_____-_____

Email:_____

How do you prefer to be reached? (Mark all that apply):

O **Mail** O **Phone-Day** O **Phone-Evening** O **Email**

Funding provided by the U.S. Administration on Aging and managed by
the Massachusetts Executive Office of Elderly Affairs and the Department of Public Health

For Program Coordinator Use Only

Participant # _____

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My Life, My Health:
Living with Chronic Conditions
Pre-Workshop Survey

Office Use Only
Received _____
AoA _____
DPH _____

Part A. Participant Information Survey

Instructions:
Please use a pen to answer the questions on both sides of this form.
Please print clearly. Please fill in the circle(s) completely, like this: ●

1. What is your date of birth? [ ][ ] / [ ][ ] / [1][9][ ][ ]
Month **Day** **Year**

2. What is your gender?

- O **Female**
- O **Male**

3. Are you of Hispanic, Latino, or Spanish origin?

- O **Yes**
- O **No**
- O **Unknown**

4. What is your race? (Mark all that apply.)

- O **American Indian or Alaska Native**
- O **Asian or Asian-American**
- O **Black or African-American**
- O **Hawaiian Native or Pacific Islander**
- O **White or Caucasian**
- O **Other:** _____

Please turn over ⇨

For Program Coordinator Use Only

Participant # __ __ Facility Code _____ Workshop Start Date ____/____/_____

Workshop Leaders _____ _____ _____

Part A. Participant Information Survey—continued

5. Has a health care provider ever told you that you have any of the fol lowing chronic conditions? (Please mark all that apply.)

- O **Arthritis / Rheumatic Disease**
- O **Breathing/ Lung Disease (Asthma, Emphysema, Bronchitis)**
- O **Cancer**
- O **Depression or Anxiety Disorders**
- O **Diabetes**
- O **Heart Disease**
- O **Hypertension (High Blood Pres sure)**
- O **Stroke**
- O **Osteoporosis (Low Bone Density)**
- O **Other Chronic Condition. Describe: _____**
- O **I am taking this course because I live with or care for someone with a chronic disease.**
- O **I am taking this course for a nother reason:_____**

_____ Total # of Chronic Conditions

6. What is your Zip Code? | | | | | |

7. Today, how many people live in your household (including yourself)? | | **(Number of people)**

8. Have you ever taken a chronic disease self -management workshop before?

- O **Yes**
- O **No**
- O **Unsure**

Please turn over

Part A. Participant Information Survey—continued

(Please remember to fill in the circles(s) completely, like this: ●)

9. How did you hear about the workshop? Select one or more below:

- O **Previous participant**
- O **Health care provider**
- O **Employer**
- O **Independent Living Center**
- O **Council on Aging/Senior Center**
- O **TV or radio**
- O **Aging Service Agency**
- O **Other** _____

10. What is the highest level of education you have completed?

- O **Less than high school**
- O **Some high school**
- O **High school graduate**
- O **Some college or vocational school**
- O **College graduate**
- O **Graduate school**

11. Is English your primary language? ..... O Yes O No

****If you responded "No", what other language do you speak? _____ __**

12. Do you provide care for someone with a chronic condition?..... O Yes O No

13. Do you use special equipment such as a cane, walker, or hearing aid? ..... O Yes O No

14. Are you limited in any activities because of physical or mental problems? ..... O Yes O No

15. Do you have any health insurance?..... O Yes O No

**** If "Yes", what is your health insurance? (Please mark all that apply)**

- O **Medicare**
- O **Medicaid**
- O **Veterans**
- O **Private Insurance, *Specify*: _____**
- O **Other, *Specify*: _____**

Please turn over

Part B. Participant Health Survey

General Health

1. In general, would you say your health is:

- O **Excellent**
- O **Very Good**
- O **Good**
- O **Fair**
- O **Poor**

2. During the past 30 days, for about how many days did poor physical health (including physical illness and injury) keep you from doing your usual activities, such as self-care, work or recreation?

_____ days in the past month

3. During the past 30 days, for about how many days did poor mental health (which includes stress, depression, and problems with emotions) keep you from doing your usual activities, such as self-care, work or recreation?

_____ days in the past month

Physical Activity

4. During the past week, other than your regular daily routine, did you participate in any physical activities or exercises, such as brisk walking, bicycling, dancing, etc.?

- O **Yes**
- O **No**

5. How many days in the past week were you physically active for at least 30 minutes such as brisk walking, bicycling, vacuuming, gardening or anything that causes you to breathe faster (it does not have to be all at one time).

_____ days/ past week

Please turn over

Symptoms

For each of the following questions, please fill in the circle above ONE number that describes your symptoms in the past week. Zero indicates no symptom at all.

(Please remember to fill in the circles(s) completely, like this: ●)

6. We are interested in learning whether or not you are affected by fatigue. Select the number below that best describes your fatigue in the past week.

No Fatigue	O	O	O	O	O	O	O	O	O	O	O	**Severe Fatigue**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

7. We are interested in learning whether or not you are affected by pain. Select the number below that best describes your pain in the past week.

No Pain	O	O	O	O	O	O	O	O	O	O	O	**Severe Pain**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

8. We are interested in learning whether or not you are affected by stress. Select the number below that best describes your stress in the past week.

No Stress	O	O	O	O	O	O	O	O	O	O	O	**Severe Stress**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

9. We are interested in learning whether or not you are affected by sleep problems. Select the number below that best describes your sleep in the past week.

No Problem Sleeping	O	O	O	O	O	O	O	O	O	O	O	**Very Big Problem Sleeping**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Please turn over ⇨

Confidence Levels

10. How confident are you that you can do the <u>different tasks and activities</u> needed to manage your health condition in order to reduce your need to see a doctor?

Not at All Confident	O	O	O	O	O	O	O	O	O	O	O	**Totally Confident**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

11. How confident are you that you can do things <u>other than just taking medication</u> to reduce how much your illness affects your everyday life?

Not at All Confident	O	O	O	O	O	O	O	O	O	O	O	**Totally Confident**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Health Care

(Please fill in just one circle for each of the items, like this: ●)

12. When you visit your doctor, how often do you prepare a list of questions for your doctor?

O	O	O	O	O
Never	**Almost Never**	**Sometimes**	**Fairly-often**	**Always**

13. When you visit your doctor, how often do you ask questions about the things you want to know and things you don't understand about your treatment?

O	O	O	O	O
Never	**Almost Never**	**Sometimes**	**Fairly-often**	**Always**

14. When you visit your doctor, how often do you discuss any personal problems that may be related to your illness?

O	O	O	O	O
Never	**Almost Never**	**Sometimes**	**Fairly-often**	**Always**

Please turn over ⇨

Health Care—continued

15. In the past <u>6 months</u>, how many times did you visit a <u>physician</u>?
***Do <u>not</u> include visits while in the hospital or the hospital emergency department*……………………………………………………_____visits**

16. In the past <u>6 months</u>, how many times did you go to a hospital <u>emergency department</u>?..._____ times

17. In the past <u>6 months</u>, how many times were you admitted to the hospital for one night or longer?..._____ times

18. In the past <u>6 months</u>, how many total NIGHTS did you spend in the hospital? ...._____ nights

19. Were any of these hospitalizations at a skilled nursing facility , convalescent hospital, or other minimum care facility?

O **Yes**

O **No**

Thank you for your help!